

SECTION 1011 PROVIDER ENROLLMENT APPLICATION

1. Date Submitted:

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| 2. Applicant's Legal Business Name as Reported to the IRS | 3. Doing Business As (DBA) Name <i>(if applicable)</i> |
| 4. Address <i>(City, County, State, ZIP Code)</i> | 5. Name, telephone number and address of person to be contacted on matters involving the application. |
| 6. State of Service <i>(Note: a separate application must be submitted for each State of operation.)</i> | 7. Current Medicare Fiscal Intermediary or Carrier |
| 8. Type of Applicant <i>(Check one)</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Physician <input type="checkbox"/> Ambulance | 9. Applicant's Medicare Identification Number Hospital _____ Physician _____ Ambulance _____ |
| 10. Hospital Election <i>(Hospital Only)</i> <input type="checkbox"/> Payment for hospital and physician services <i>(Note: Hospitals electing to receive payment for both hospital and physician services must complete Attachment 1.)</i> <input type="checkbox"/> Payment for hospital and a portion of on-call payments made by the hospital for physician services. <i>(Note: If a hospital elects this option, physicians will separately bill for section 1011 services.)</i> | |
| 11. Physician Privileges <i>(Physician Only)</i> If a physician has privileges at multiple hospitals, then the physician must complete Attachment 2. | |
| 12. Applicant's Federal Tax Identification Number | 13. Applicant's Routing Transit Number, Deposit Account Number <input type="checkbox"/> Checking <input type="checkbox"/> Savings |

ALL PROVIDERS

In order to receive payment under section 1011 of the Medicare Modernization Act of 2003, the provider submitting this enrollment application agrees to collection requirements approved under the Paperwork Reduction Act. This agreement, upon submission by the provider of services and acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

The provider, hospital, physician, ambulance company, or any other person or entity receiving section 1011 payments (hereinafter "payee") acknowledges that those payments may be retroactively adjusted at the end of each fiscal year in accordance with subsection (c)(2) of section 1011. If CMS determines that payments must be retroactively adjusted, the payee agrees that it will promptly remit the full amount of the reduction to CMS in accordance with instructions provided with the notice of retroactive adjustment. Payee acknowledges that there will be no appeal or review of the determination of retroactive adjustment. Any payment owed to CMS must be remitted promptly, but in no event later than 30 days after notice.

HOSPITALS ONLY

I agree to provide patient eligibility information to physicians and ambulance providers within 120 days of the date of service. I agree to notify the physicians within my hospital about my payment election (see item 10 above.) I further agree to reimburse physicians in a prompt manner after receiving section 1011 reimbursement and agree not to charge an administrative or other fee with respect to transferring reimbursement to a physician.

ATTENTION: READ THE FOLLOWING PROVISION OF FEDERAL LAW CAREFULLY BEFORE SIGNING.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000, imprisoned not more than 5 years, or both (18 U.S.C. section 1001).

To the best of my knowledge and belief, all data in this application are true and correct, and the governing body of the applicant has duly authorized the document.

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| 14. Type Name and Title of Authorized Representative | 15. Telephone Number <i>(including area code)</i> |
| 16. Signature of Authorized Official | 17. Date |

The purpose of collecting this information is to determine or verify the eligibility of individuals or organizations to enroll in the section 1011 program as providers. This information will also be used to ensure that payments are made to eligible providers as described in section 1011(e)(4) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. All information on this form is required. Without this information, the ability to make payments will be delayed or denied.

This application allows eligible providers to apply to receive payment for some or all of their unreimbursed costs of providing services required by section 1867 of the Social Security Act and related hospital inpatient, outpatient, and ambulance services furnished to undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the U.S. with a laser visa.

APPLICATION SUBMISSION

To enroll in this program, provider must **MAIL** an original copy of the **APPLICATION** to the following address.

TrailBlazer Health Enterprises, LLC.
Section 1011
P.O. Box 660529
Dallas, Texas 75266-0529

In addition, each provider is required to complete and transmit this **APPLICATION** via the designated contractor web site. (This website will be available later this year.) Providers will be notified of the website when it becomes available.

APPLICATION DEFINITIONS

To help you understand certain terms used in this application, we have included the following definitions.

Authorized Official – An appointed official to whom the provider has granted legal authority to enroll it in section 1011, to make changes and/or updates to the provider’s financial information, and to commit the provider to fully abide by the laws and program instructions of section 1011. The authorized must be the provider’s general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of five percent or more of the provider or must hold a position of similar status and authority within the provider’s organization.

Hospital – is defined at section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

Legal Business Name – The name that is reported to the Internal Revenue Service (IRS) for tax reporting purposes.

Medicare Identification Number – This is a generic term for any number that uniquely identifies the provider. One example of a Medicare identification number is the Unique Physician/Practitioner Identification Number (UPIN).

Physician – is defined at section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

Tax Identification Number – This is the number issued by the Internal Revenue Service (IRS) that the provider uses to report tax information to the IRS.

APPLICATION REQUIREMENTS

We will use all the information you submit for enrollment and claims validation purposes.

FINANCIAL INFORMATION

The information concerning your financial institution should be available through your organization’s treasurer or financial institution. A contact person and telephone number are important for verification purposes. Your financial institution can assist you in providing the correct banking information, including the bank’s routing number.

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ATTACHMENT 1

This attachment is only required for hospitals electing to receive section 1011 payment for hospital and physician services and must list the names and provider numbers of physicians with hospital privileges.

[illegible]

ATTACHMENT 2

Physicians with hospital privileges at more than one hospital must list the names and provider numbers of hospitals where they have privileges.

[illegible]